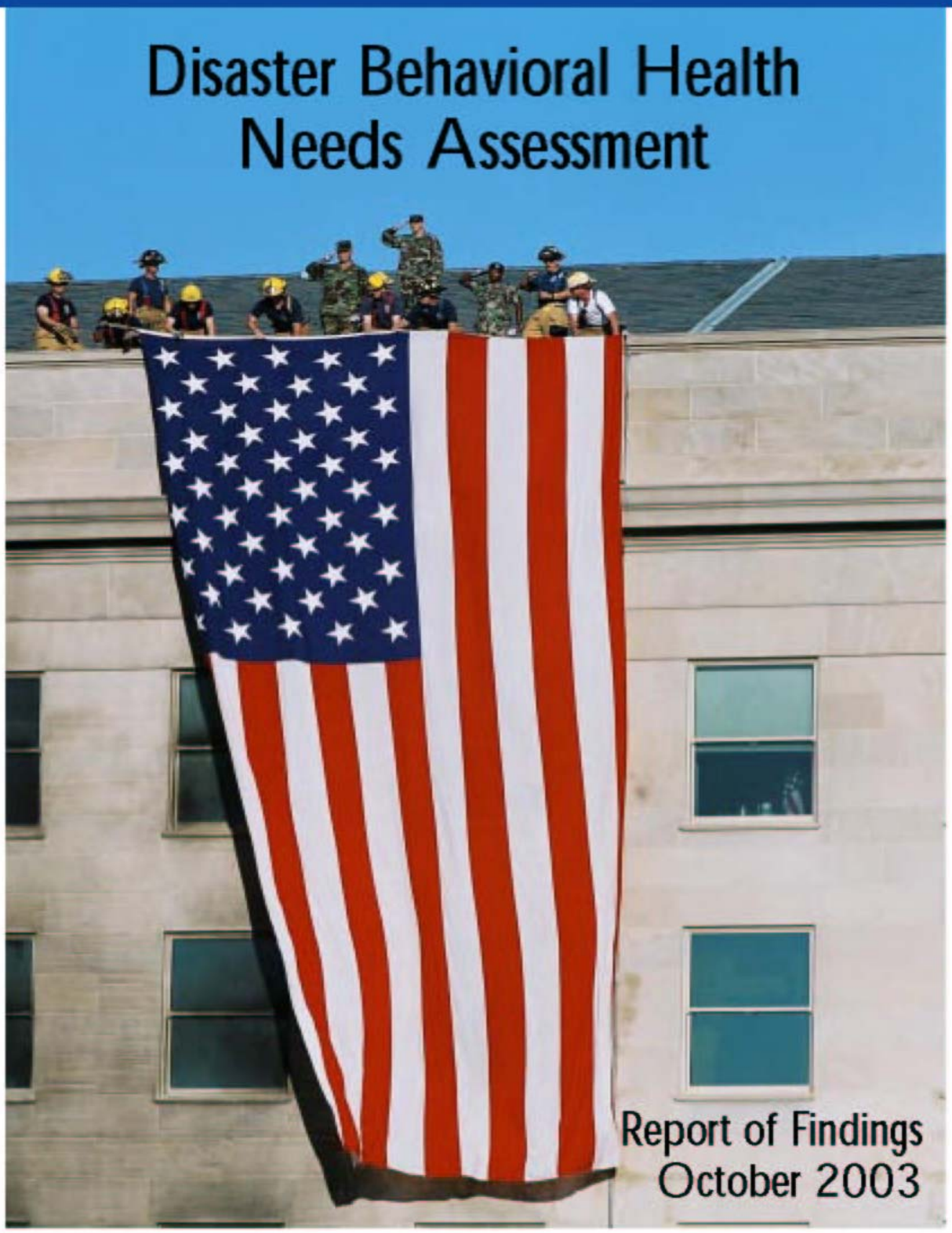
Disaster Behavioral Health Needs Assessment



Report of Findings
October 2003

New Hampshire Department of Health & Human Services
Division of Behavioral Health

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I. Introduction

On September 11, 2001 the United States experienced the devastating and horrific terrorist attacks on the World Trade Center in New York City, the crash of a highjacked United plane in Pennsylvania and the crash into the Pentagon. New Hampshire residents watched along with the world, the unfolding events of loss, trauma and grief. These events had an effect on all of us. Some were impacted more than others. A pilot of one of the planes was a resident of New Hampshire. Thousands of New Hampshire citizens knew someone personally who had been killed in these attacks. Many more were traumatized by what they watched on television. Vulnerable populations such as those suffering from serious mental illness, substance abusers, children and the elderly were impacted in such a way that they required special attention, support and comfort. The needs of these at-risk populations will continue and change over time. The events of September 11th, the continuing terrorist threats and the war with Iraq have provoked a widespread uncertainty and anxiety among the citizens of New Hampshire. We are in the midst of experiencing unprecedented fear, anger and irritability by the general population. Our daily routines and sense of "normalcy" has changed. Each person's response is unique, based on his or her environment, culture, beliefs, trauma history health, and personal resiliency. The Division of Behavioral Health, community mental health centers, Red Cross Chapters, local hospitals and other behavioral health providers play an important role in promoting preparedness, resilience and coping with the continuing threat of terrorism. More than any time in our history, the general public is serious about being ready for future events from both a physical and psychological perspective. Families are discussing what they should do as they develop their personal disaster plans. Schools are updating their disaster response plans. Many New Hampshire residents however, do not understand the connection between the terrorist events and the psychological reactions they may be experiencing. For these individuals, new mental health interventions and approaches may be necessary to assure them that the stress reactions they are experiencing are considered "normal" reactions to an abnormal situation.

The State of New Hampshire is committed to preparing for and responding to episodes of terrorism and other public health emergencies that may affect our state. The Center for Disease Control's Public Health Preparedness and Response for Bioterrorism Cooperative Agreement Program provides much needed funds to support ongoing efforts to strengthen and improve the public health system in New Hampshire, particularly our ability to respond to bioterrorism attacks and other public health emergencies. Following the tragic and historic events of September 11th and the anthrax attacks along the east coast, New Hampshire state and local government agencies, private business and many other volunteer organizations have been reviewing their efforts to respond to the new threats of terrorism and increasing their efforts in notable ways.

In the late fall of 2001, the Governor's Commission on Safety and Preparedness composed of key leaders in the state response to terrorism was formed. The New Hampshire Department of Health and Human Services (DHHS), as a member of the commission, has been charged with and has undertaken a number of activities to both improve and prepare for health related consequences of an attack. In particular, DHHS is a key first responder for episodes of biologic, chemical and radiation terrorism and for

any event where substantial numbers of persons may have illness, death or disability. Responding to bioterrorism requires the cooperation and coordination of public safety, public health, behavioral health and emergency medical professionals. While public safety has been the traditional responders to terrorist events and will play a central role in investigation and disaster management, bioterrorist threats require medical and public health officials to initiate comprehensive surveillance programs to facilitate the timely identification of such an attack and to issue guidelines that will mount an appropriate public health response to reduce illness and deaths.
The statutory lead for public health activities in New Hampshire resides with the Office of Community and Public Health (OCPH) within the DHHS. OCPH is strategically situated within state government to be in a leadership position to facilitate the coordination and interagency collaboration that is necessary to plan, mount and sustain a credible response in the event of a public health emergency. Elderly and adult care, health facility regulation, food protection, behavioral health services, Medicaid administration, information technology support and other administrative and technical support functions reside within the DHHS and will play additional critical roles during a public health emergency.

The small geographic size of the state, the commitment of first responders to collaboration, well-developed organizational relationships between key stakeholders and a strong ethic of volunteerism among New Hampshire citizens facilitate response to all forms of emergencies. However, weaknesses exist in public health response capacity as recently cited in the Governor`s Commission on Safety and Preparedness report. Two such weaknesses of most concern are; 1) the need for general upgrading of the emergent response infrastructure for bioterrorism, chemical and radiation response and 2) the need for a coordinated public health system at the local level. These needs are consistent with the federal legislative intent to address the dual purpose of building immediate emergency response capacity to bioterorism and building public health infrastructure.

In the State of New Hampshire 2002 Public Health Preparedness and Response to Bioterrorism Cooperative Agreement Work Plan-Focus Area A: Preparedness Planning and Readiness Assessment, Goal 1 seeks to " Establish strategic leadership, direction and coordination and assessment of activities to ensure state and local readiness, interagency collaboration and preparedness for bioterrorism, other outbreaks of infectious disease, and other public health threats and emergencies". To support this goal Objective 1D was established. It attempts to " Conduct an assessment of mental health system capacities on the state and local level related to bioterrorism or other public health emergency to improve planning, coordination and response." The method/plan to achieve this objective is as follows. The aftermath of the Oklahoma bombing and September 11th terrorist attacks overwhelmed state and local mental health agencies. Five years later, data from Oklahoma suggests that the impact of the attacks not only created an acute need for mental health services as a result of the mass casualties, but also for long term, sustainable mental health services. In collaboration with the Division of Behavioral Health, its Community Mental Health Centers and public and private mental health providers, an assessment of current mental health system capacity will be conducted with the goal of establishing a plan that is prioritized and identifies needed resources to

enhance the current infrastructure as part of the overall emergency preparedness planning specifically in the integration of primary care with mental health services at the local level. This would be the first time that an assessment of the disaster mental health needs and capacity will have been conducted in New Hampshire. OCPH will work with the Division of Behavioral Health to recruit a Mental Health Emergency Coordinator (Administrator I, LG 27) with appropriate credentials to spearhead this effort. A consultant will be engaged under contract to assist in the design, implementation and analysis of the results from the assessment tool. In addition, funds will be used to support the design, implementation and analysis of an assessment tool and to conduct workshops and trainings specifically focused on the mental health response to a public health emergency. The budget for this activity in the CDC grant was $10,000.

In January, 2003 a Mental Health/ Substance Abuse Disaster Coordinator was hired with CDC funds to support not only the needs assessment effort but to develop a state behavioral health disaster plan, integrate behavioral health with public safety and public health and to implement a SAMHSA training program for behavioral health professionals. In addition to these major duties, this position will develop a library of materials for the general public, form disaster response teams in five regions of the state and create a database of behavioral health professionals available to provide disaster-related clinical services.

In March 2003 a literature search for recent national experiences in disaster mental health needs assessment was conducted. In addition, the Disaster Mental Health Technical Assistance Center (DMHTAC), a division of SAMHSA was contacted in an effort to see if any mental health needs assessment tools existed. Shortly after September 11th, the Center for Mental Health Services supported an initiative to assess the mental health needs of each of the states affected by the terrorist attacks. CMHS asked the states to identify their immediate and longer-term mental health service response requirements and recommend service and system enhancements that would improve their mental health capacities in the event of future terrorist attacks.

In November 2001, the Commonwealth of Virginia produced a report entitled "Terrorism-Related Mental Health Needs Assessment." This report and the structured interview form was most helpful to New Hampshire. Two other sources of assistance were the New Hampshire Disaster Behavioral Health Advisory Committee (DBHAC) and the Training Institute of the Mental Health Center of Greater Manchester. The DBHAC whose mission is to " oversee the development/maintenance of an enhanced behavioral health system designed to prepare for and respond to disasters" was very supportive of the needs assessment effort. This Committee is comprised of representatives of various behavioral health providers, the American Red Cross; the faith based community, emergency management planners, the state hospital association, and employee assistance professionals. Several members of the Training Institute with experience in survey design provided technical assistance to the MH/SA Disaster Coordinator in the development of the survey instrument. The DBHAC reviewed various drafts of the instrument providing input as to both the content of the instrument and the process for obtaining the data. It was decided that the interviews should be of a structured

interview format, conducted in-person whenever possible. In some instances, over the phone interviews would be allowed due to geographic or time limitations. In no instances however would the form be mailed out and returned without the opportunity for clarification and dialogue. After several drafts and edits the Disaster Behavioral Health Needs Assessment and Preparedness Survey was completed and available for use on May 30, 2003. In May 2003 an advertisement was placed in the Union Leader soliciting consultants to conduct the needs assessment. Four contractors with behavioral health and/or interviewing experience were selected to assess the following:

1. the current on-call systems of behavioral health providers
2. the behavioral health resources that each region has used in the past to respond to disasters
3. the current capacity of behavioral health providers to respond to all levels of disasters
4. training needs
5. the partnerships/relationships among various entities involved in emergency preparedness and response and
6. the factors that may influence future demand for disaster mental health services

Four Contractors were selected to conduct the interviews. They were: Donna Hastings, Toni Paul, Fred White and Steve Thurston. The contractors performed this work simultaneously in order to obtain information in a timely fashion. The state was divided into four regions. A training session was held to provide the contractors with the necessary instructions, contacts and materials in order to promote interviewer consistency, reliability and validity. It was determined that each contractor would begin the process by interviewing a representative of the Community Mental Health Centers in their assigned region. The instrument had been shared in advance with the Executive Directors and the Emergency Services Directors of the Community Mental Health Centers. It was expected that the CMHC would be helpful in identifying other key behavioral health providers in their community that should be interviewed. It was also an expectation that the contractor would interview the local Red Cross Chapter and local community hospitals in their region. The ARC-Concord Chapter and the New Hampshire Hospital Association were helpful in identifying contacts in each of these organizations.

Two key approaches were adopted. First, in keeping with the national "All-Hazards" approach adopted by federal and state agencies, the needs assessment would focus on preparedness, capacity and response to any form of disaster not just terrorism. Second, the DBHAC emphasized a "behavioral" health rather than a "mental" health perspective so as to be more inclusive and avoid stigmas commonly associated by the general public. An effort was also made to include substance abuse providers in each region as they have traditionally been excluded in disaster planning and response activities. The substance-abusing clients currently receiving services and the risk for substance abuse following a disaster necessitates the involvement of these service providers. The Division of Alcohol and Drug Abuse Prevention and Recovery was also very helpful in identifying candidates to be interviewed, supplying each contractor with a Resource Guide. A list of organizations interviewed can be found in **Appendix A**. The contractors conducted

interviews with a total of 55 key informants and behavioral health professionals. Of the 55 interviewed, 14 were Community Mental Health Centers (this included the CMHC main offices as well as some area offices), 8 Red Cross Chapters and 16 community hospitals. The remaining respondents included first responders, the Salvation Army, health departments, health consortiums, VNA's, CISM teams, substance abuse providers and social service agencies. **Appendix B** is a narrative summary of the Consultant Interviewers regarding the needs assessment process. **Appendix C** is the advertisement that appeared in the Union Leader for Consultant interviewers. **Appendix D** is the Disaster Behavioral Health Needs Assessment Tool that was utilized. **Appendix E** is the Summary Data Form used to tabulate result from all four regions. The names of people nominated to serve as members of the Disaster Behavioral Health Response Teams has not been included to protect the privacy of those individuals.

II. Assessment of Need- the responses to the Needs Assessment Interviews are described below.

A. Community Related

1. Past Methods of Coping- the most common methods of coping with disasters in the past have been: critical incident stress management (36), support groups (35) and crisis counseling (38). CMHC also provided many public education forums after a disaster event. Hospitals and the American Red Cross relied most on support groups. Other methods listed were reality checks, fire/police grief groups, hospice, EAP's, informal crisis response teams, Victims Inc., and chaplains/ministers. It appears that there is a need for more outreach and mental health screenings.

2. Current Resources- Most respondents appeared to know what the resources in their community to respond to disasters were as there were no "don't know" answers. The Red Cross was by far the resource that most people were familiar with (48 responses) followed by the faith community (28), Emergency Management (27), Salvation Army (26), and CISM teams (24). It is clear that the Citizen Corps is still a new concept to most, receiving only two responses. Other resources included informal networks, Granite State CISM Team, private practitioners, LEPC's, emergency psychiatry, EAP's, NHVOAD, school response teams, hospitals and community mental health centers.

3. Participation in planning efforts- 92% of those who responded to this question stated that they participated in local, regional, or statewide committees, task forces or other efforts related to disaster planning. This included 71% of the CMHC participating in the survey, 88% of the Red Cross Chapters and 94% of hospitals. The New Hampshire Hospital Association has done an excellent job of involving the community hospitals in planning for disasters. Examples of participation were varied and included: the local Red Cross Chapter, the Division of Behavioral Health-Disaster Behavioral Health Advisory Committee, the Mayor's Anti-Terrorism Task Force, State CISD team, local police/fire committees, DBH-Emergency Services Directors meetings, Community Health and Safety Initiative, Lancaster Crisis

Response team, statewide hospital disaster planning group, local smallpox planning committees, NHHA Task Force, Region 1 District EMS Councils, statewide Bioterrorism Emergency preparation committee, EMS/Public Health Interaction Collaborative, LEPC-Laconia, Hazard Mitigation, local crisis response teams, local EMS, Lebanon Emergency Planning Committee, LEPC's-Lebanon and Hanover, Mascoma Valley Health Initiative, Vermont State Committees, NHHA, Emergency Department Nurses, Rochester school district crisis plan, Northern Strafford County Health Alliance, community table top drills, Portsmouth biohazard drill, SW/NH Regional Planning Committee, LEPC-Nashua and Merrimack EMA.

4. Leadership- 80% of respondents were aware of the individual who takes a leadership role or who is responsible for emergency management/planning response in their community. All Red Cross Chapters (100%) were aware, 81% of hospitals and 64% of community mental health centers. There is clearly a need to improved communication and collaboration especially with the CMHC.

5. Inter-Agency Agreements- Only 62% of respondents were aware of any interagency agreements in their community that specified roles, responsibilities and expectations of each other in the event of a disaster. Respondents did however provide the following examples: mutual aid agreements between fire departments, Littleton Hospital/Public Safety officers, EMS/Fire mutual aid, Police mutual aid, Lakes Region Mutual Aid Fire Association, CMHC/Claremont school district, CMHC/Valley Regional Hospital, CMHC/Newport School District, ARC/Shelter agreements at local level, ARC/National MOUs with other National organizations, FEMA/Hospitals, ARC/Mutual Aid compact, vendor agreements, collaborative hospital agreements, EMS collaborations and mutual aid agreements, Monadnock Family Services/Cheshire Medical Center, Keene EMA plan, Community Council of Nashua/Nashua Public Health Dept. MOU, New Hampshire Hospital Association Mutual Aid agreement, and the National Disaster Medical System.

6. Cultural Competency- 50% of those who responded to this question stated that their disaster plan included culturally competent and linguistically appropriate services. The CMHC (50%), ARC (80%) and Hospitals (53%). 40% replied that their plan did not include a cultural competency component and 10% did not know. Some specific descriptions of services included: the AT&T language line, bi-lingual staff, VA database, in-house interpreters, ARC-Diversity training, local language banks, list of hospital interpreters, Lutheran Child and Family services statewide plan, college language professors and foreign students, churches, ethnic restaurants, ARC literature (14 languages), and Public Health interpreters.

7. How disaster behavioral health response could be improved in community-

Overall Responses:

- Set up agreements with local community mental health center
- Become aware of needs of visually impaired and at-risk populations
- More public awareness about disasters-state should put together resource manual

- More local involvement in planning
- Improve communication
- Formal agreements and linkages should be written into City plan
- More knowledge of languages and money for interpreters
- More public awareness and education on behavioral health and disasters, where to go for help and what are normal reactions
- Relationship building between responding agencies
- Need an integrated team. Be willing to formalize relationships
- Need dialogue among service providers
- Develop a local volunteer network of translators
- Have individuals who are occupying beds in the ED due to mental health issues get assessed and moved along
- Create a system to oversee resources
- Better plan for follow up post disaster
- Break down barriers between agencies
- Establish a community disaster task force in each community
- Provide more training

CMHC Responses:

- Communications and networking with other agencies. Have a relationship with police, fire and corrections
- Better communication between local and state practice
- Need incentives for training as it is not billable time and there is lost revenue
- Recruit more mental health providers into community
- Increase funding to compensate for time spent on planning and training activities
- Surge capacity resources
- Have a structured and trained disaster response team with an identified leader
- More local drills
- Better awareness of CMHC as community resource
- Need community groups to organize and have their role clearly articulated in the local disaster plan
- Don't reinvent the wheel. There is an overlap of responsibilities at county and local levels

ARC Responses:

- More networking. How do we reach the right person to make the right calls?
- Interagency training and awareness so each understands their capabilities and limitations
- Need to keep volunteers interested and involved with training, drills, etc.
- ARC needs to be notified to provide services
- Familiarize first responders with basics regarding behavioral health
- Increase overall cultural competence training

Hospital Responses:

- Improve linguistic resources
- Increase personnel resources
- More education for community
- Increase communication ability between agencies

- Increase mental health resources in North Country
- Planning for small-scale disasters
- Update disaster plans to include mental health component
- Need formal links with CMHC. Identify what types of services are needed and when. Build into drills.
- Need for cross training. Mental health professionals need more training on disasters in general and disaster responders need mental health training
- Better coordination of roles. Eliminate redundancy.
- Develop and distribute a list of community resources available for disaster response

B. Agency-Related

1. Provision of services since 9-11- 64% of respondents stated that they have provided services to people who were affected by terrorist activities since September 11th. This included 72% of the CMHC, 88% of the Red Cross chapters and 56% of hospitals. Various services were provided such as: responding to individual needs, family support groups, individual assessments, public education, sending volunteers and materials to N.Y.C., short-term counseling for existing clients, medical services to persons directly involved in N.Y.C., hospital chaplain services to friends of victims, community education and training, created website for resources and referrals, crisis intervention, psychotherapy, outreach to schools, created new brochures, hotline crisis and addiction counseling, seminars for local companies, work with military families, depression/anxiety screenings, and Disaster Response Network Psychologists acceptance of referrals (pro bono).

2. Current disaster related services- the most common disaster related services currently being provided are family groups/meetings (41), 24-hour emergency services (38), crisis counseling (36), community groups/forums (28) and school-based groups (28), psychotherapy (25), and CISM (22). Respondents also mentioned that they provide grief groups, education, addiction counseling, forensic evaluations, and EAP services.
3. Disaster-related services in planning stage- twenty three respondents stated that they are in the process of developing disaster related services including crisis counseling, community groups, school-based groups, 24 hour emergency services, CISM, staff training, emergency planning, community education, "facing fear" programs for schools and more training by the ARC.

4. Disaster-related material for general- public- 54% of the respondents stated that they currently have disaster-related materials such as media releases, flyers, and info. for high risk groups that could be disseminated to the general public. This included 57% of the CMHC, 100% of the Red Cross chapters and 31% of hospitals. 96% of the respondents said that they would be interested in obtaining such materials. There is an obvious need to get materials into the hands of the CMHC and hospitals for distribution.

5. Disaster Response Plans- 76% of the respondents have an external disaster response plan (CMHC-71%, ARC-100%, and hospitals-94%). 51% of respondents stated that their agency was part of a hospital plan that included a mental health component, most notably 64% of the CMHC. This illustrates the need for including CMHC in hospital planning efforts. 80% of respondents have a plan to mobilize and release staff from their agency to respond to disasters (CMHC-86%, ARC-100% and hospitals-60%). Overall there are 464 professionals available with direct experience to respond including 133 staff from CMHC, 158 ARC volunteers and 108 hospital staff.

6. Staff training and experience- 69% of the agencies who responded have staff members who have had some training in disaster mental health issues (CMHC-93%, ARC-88% and hospitals-53%) thus demonstrating the need for more training of hospital staff on mental health issues. 75% of respondents stated that they have an up-to-date list of skilled staff that includes training, credentials, experience and contact information (CMHC-79%, ARC-88% and hospitals- 60%). Agencies with staff that are available to respond to disasters and have had experience in responding to the following types of disasters: suicides (38), homicides (30), natural disasters (29), large scale, federally declared disasters (20) and terrorist activity (19). Other examples of direct experience were fires, auto accidents, floods, power outages, kidnapping, bomb threats, airline crashes, bank robberies, mass casualty incidents, school grief work, deaths, and chemical spills. Only five agencies reported that none of their staff have had experience in responding to disasters.

7. Assessing needs of victims- only- 36% of respondents have a method/tool for assessing the behavioral health needs of victims immediately following a disaster (CMHC-43%, ARC-63% and hospitals-38%). Examples of assessment tools currently being used are: PCLS, EAP assessments, lethality assessment, depression screening, CISM-Mitchell model, ES Contact sheet and Suicide Risk assessment.

8. Needs of first responders- 64% of respondents have a plan to manage the emotional/behavioral needs of first responders (CMHC-64%, ARC-75% and hospitals-73%).

9. Participation in Drills- 57% of the respondents have participated in disaster training or mock drills/simulations in their community (CMHC-22%, ARC-88%, and hospitals-93%) There was a wide range of activity such as decontamination drills, hostage situation, chemical, nuclear aviation, kidnapping, smallpox, school shooting bomb threats, anthrax, radiation, earthquake, building collapse, local hospital-based drills, auto crash into a large crowd, haz-mat, terrorism floods, mass disasters-table top, bus accident, set up of field hospital with National Guard, Pease airport disaster drill, Hampton WMD exercize-2003, TOPOFF-2000, Seabrook station disaster drill, Manchester airport drill, Hollis Fire drill, Vermont drills, Vermont Yankee, Community Council of Nashua with SNHMC, ARC with chemical spills and airport disasters, SNHMC disaster recall list, CISM simulations and ARC drills.

10. Training Needs- there was widespread support for training of staff and community members. Most of the areas listed as possible topics in the survey were seen by respondents as welcome.

The needs in order of preference were:

- Roles, responsibilities and resources of disaster response agencies (38)
- Crisis counseling (34)
- Effective interventions with disaster survivors (33)
- Prevention and management of stress among disaster mental health workers before, during and after incident (33)
- Critical incident stress management (32)
- Effective interventions at the community level (32)
- Key concepts of disaster mental health (32)
- Effective interventions of first responders (31)
- Disaster response protocols (31)
- Special populations concerns in a disaster (30)
- Identifying disaster related behavior (29)
- Post traumatic stress syndrome (28)
- Red Cross disaster mental health training (26)
- Disaster recovery process (25)

Other topics requested were: needs of the handicapped, understanding the command center role, how to deal with large-scale disasters, community roles in disasters, regional planning roles and responsibilities, communication protocols/systems, understanding terrorism, introduction to disaster for community at large, hands-on training, Incident command system, and hazard recognition.

11. Provider Directory- 83% of the respondents would be willing to accept referrals after a disaster by being part of a statewide directory of providers for disaster behavioral health (CMHC-100%).

12. Barriers/limitations to being able to fully implement a disaster response plan in agency

Overall Responses:

- Money to pay staff
- Limited staff available
- Volunteers need more training
- Need awareness of special needs
- Time and money
- Confidentiality of clients
- Releasing staff for training may compromise services to existing clients and impact revenue stream
- Point person needed to handle mental health issues
- Lack of training and funding for training
- Getting M.H. workers trained to work as volunteers

- Understanding by existing systems of the role of behavioral health response teams
- Cross training
- Overall lack of awareness and concern of disaster issues

CMHC Responses:

- Staff resources
- Financial
- Time
- Having an appropriate plan
- CEU's for training
- Finding time for staff to attend training without impacting the bottom line
- Stigma associated with mental health may prevent some disaster survivors from seeking assistance
- Turf issues. Need to build bridge between police, schools and CMHC
- Limited # of mental health providers
- Potential immobilization of staff& community if and when a disaster does strike
- Distance to travel for training
- Staff too busy with current client and day to day issues
- Pressure to meet productivity/revenue goals
- Getting the community on board
- Lack of coordination. Who is doing what?
- Lack of good training
- Need to work the process-better communication and organization at County and regional level. Need a key person identified in each community
- Inability to deploy large numbers of staff on short notice, particularly during work time as funding is dependent upon seeing clients.

ARC Responses:

- Apathy. Not enough disasters in New Hampshire and volunteers lose interest
- Mostly an all-volunteer agency
- Building disaster action teams to include mental health/special populations
- Large scale disasters cover many communities and there may be too many
- Incident Commanders
- Lack of awareness of ARC or won't call because of stigma (blood only)
- Funding
- Lack of LEPC's in all cities and towns
- Maintaining interest of volunteers
- More endorsement of mental health component-image and perception

Hospital Responses:

- Lack of behavioral health specialists
- Too much information arriving from the state. It changes and not everyone has the same information.
- Financial
- Appropriate training
- Need for large-scale drills using behavioral health interventions

- Direction and guidance
- Time, people and resources
- Funding for staff positions and equipment
- Lack of coordination and communication among agencies
- Lack of Hospital Incident Command System
- Need training and leadership not federal dollars
- No one is coming into Plymouth area to help
- There is no one person to coordinate and be accountable
- Need to build disaster behavioral health into hospital ICS protocol
- Looking for state to provide guidelines/checklists with timelines for when services are needed
- Training shouldn't be agency specific but rather cross agency.
- More education
- Different agencies are using different communication equipment
- Capacity and duration

III. Recommendations for System Enhancements and Improvements in New Hampshire's Behavioral Health Planning, Preparedness and Response Capacity

1. Include behavioral health representation in planning and preparedness activities and not just as a response resource. There is a need for improved collaboration, coordination and communication between public safety, public health and behavioral health at both the local and statewide levels.

2. Include a behavioral health component in all emergency management plans, hospital disaster/safety plans and local Red Cross Chapter plans. These plans should specify the role of behavioral health and how the various response entities will work together in the event of a disaster. Review and update disaster response plans at least annually.

3. Activate local emergency planning committees with representation from the local community mental health centers. An alternative would be to establish regional disaster planning committees. Identify leadership preferably from the Bureau of Emergency Management. Make these leaders visible, responsive and accountable. The focus of these committees would be to promote linkages among agencies, break down barriers between agencies, establish a communications network, develop procedures/protocols and develop formal mutual aid agreements.

4. Provide training on a wide variety of disaster-related topics to behavioral health professionals as well as training on the mental health impact of disaster to first responders. The training should have built-in incentives, be low / no cost and accessible to all interested parties. Strategies should be explored as to how to provide training for clinicians whose agencies depend on their ability to generate revenue with the understanding that time out of the office impacts the bottom line.

5. Training and planning should be followed up with regular testing through local and statewide drills and exercises that include a behavioral health response. The objective

of the exercises should be to test the behavioral health disaster response plans and to promote mental health care for first responders. Behavioral health representatives should be involved in the development of these exercises.

6. Develop educational materials for the general public that address the psychosocial impact of disasters. Make these materials available to community agencies free of charge in both paper and electronic forms. These materials should be sensitive to the needs of visually/hearing impaired as well as culturally competent.

7. Share interpreter and translation service with those agencies that are in need of them. Develop local networks of volunteer interpreters.

8. Train primary care and emergency medical personnel to recognize and appropriately refer individuals who may need mental health and substance abuse services before, during and after a disaster.

9. Develop media relationships and provide information in the form of press releases, alerts, PSA's and public affairs program presentations.

10. Develop a coordinated system for sharing information among all disaster planning and response agencies.

11. Establish linkages with the faith community. Involve them in planning, training, exercises and community outreach.

12. Develop resiliency enhancement and education programs for the general public.

13. Develop instruments for assessing individual and community behavioral health needs following a disaster. Train behavioral health professionals in the use of these instruments and procedures for referring those with extensive needs.

14. Raise the awareness of behavioral health professionals about the impact of terrorism through professional education programs.

15. Prepare a behavioral health surge capacity through training of disaster behavioral health response teams, development of mutual aid agreements and utilization of paraprofessionals.

16. Conduct regular screenings such as depression and anxiety for the general public for the purpose of monitoring mental health in the community and to refer those who may need behavioral health services.

17. Develop disaster response teams that have leadership and are well integrated. There is a need to recruit more behavioral health professionals especially substance abuse providers with an interest in disaster behavioral health. Provide training for these teams and have them participate in exercises in their community.

18. Create opportunities for dialogue about disaster planning and response issues among service providers.
19. Promote community mental health centers as a resource in disaster planning and response.

20. Avoid overlap and duplication of resources at both the local and state level.

21. Maintain the interest of volunteers through ongoing training, regular participation in exercises and recognition of their contributions.

22. Develop and maintain a Provider/ Resource Directory for each region that includes behavioral health providers and how to contact them.

23. Ensure that information being distributed from the state is timely and consistent. Everyone should have the same information.

24. Promote Incident Command System among all response agencies. Provide training in this approach.

APPENDIX A: ORGANIZATIONS INTERVIEWED

ORGANIZATION	PERSON (S)	DATE
Carroll County M.H.	Margaret Reiser, Dennis Mackay, Eric Johnson	9/10/03
Upper Ct. Valley M.H. Services	Charles Cotton	9/10/03
Androscoggin Valley M.H.	Arthur Froberg, Laurie Brodeur, Kim Sias, Ken Bardi	9/10/03
White Mtn. M. H.	Jane Mackay	9/10/03
Mt. Washington Valley ARC	Terri Goldblatt	9/10/03
Cottage Hospital	Barbara Brown	9/05/03
Littleton Hospital	Bruce Brown	9/05/03
North County Health Consortium	Martha McLeod	9/15/03
Lakes Region Gen. Hosp.	John Prickett	9/11/03
Genesis-Laconia	Amy Sullivan	9/16/03
Genesis-Plymouth	Celia Giggs	9/05/03
Speare Hospital	Dr. Alex Medlicott	9/15/03
Grtr. Wt. Mtn ARC Chapter	Kristine Olson	9/16/03
Horizons Counseling Center	Jackie Abicoff	9/02/03
West Central Services	Fred Hesch	9/18/03
Central Vt. /N.H.Valley ARC	Jack Shoenberg, John Stewart	9/08/03
Headrest	Caty Iacuzzi	9/18/03
Lebanon Fire Department	Steve Allen	9/18/03
Dartmouth Hitchcock Medical	Neal Boucher, Lindsey Waterhouse, Mark Hendrix	9/18/03
Valley Regional Hospital	Michelle Rowland, Janet Farley	9/18/03
MHCGM	Ken Snow, Mark McSweeney, Robin Vergato	7/18/03
Elliot Hospital	Sandi Demars, Betty Welch	7/31/03
Farnum Center	Donna Abell, Fred White	8/01/03
ARC-Manchester Chapter	Phil St. Cyr	8/01/03
Catholic Medical Center	Harold Boyer	8/01/03
Visiting Nurses Association	Celeste Tomich	8/01/03
Manchester Health Dept.	Tim Soucy	8/01/03
Salvation Army	Capt. Andrew Ferreira. Karen Conlon	8/22/03
Riverbend Emergency Services	Wayne Castro	8/05/03
ARC-Concord Chapter	David Coombs	8/05/03
N.H. Assoc. for the Blind	Jean Jaworski	8/05/03
Concord General Hospital	Michael Melody	8/07/03
Franklin Hospital	Kathy Fuller, William Valley	8/26/03
Center for Life Management	Ed Cooney	8/25/03
Parkland Medical Center	David Lacaillade	8/12/03

Hampstead Hospital	Scott Ranks	8/25/03
Salvation Army	Joshua Lyle	8/25/03
Northeast Rehabilitation	Barbara Towney, Marie Sullivan	8/12/03
ORGANIZATION	**PERSON (S)**	**DATE**
ARC-Great Bay Chapter	Paul Clark	9/19/03
B.H. & Dev. SVCS -Strafford Cty.	Steve Arnault	7/26/03
Kohut Counseling	Bill Kohut	8/20/03
DHHS - Portsmouth	Diane Smith	8/08/03
Salvation Army	Capt. Bob Kountz	8/15/03
Frisbee Memorial Hospital	Doug Martin	8/27/03
City of Dover-Fire	Perry Plummer	8/01/03
Exeter Hospital	Phil Kendrick	8/01/03
Seacoast Mental Health	Eric Johannesson, Bev Newberry	8/15/03
So. NH Med.CTR.	Bill Brown, Geraldine Deragon	9/16/03
St. Joseph's Hospital	Steve Shuster	8/28/03
NH Psychological Assn.	Donna Hastings	8/25/03
Monadnock Fam. Services	David Garbacz	9/08/03
Keene State CISM team	Judith Putzel-Price	9/05/03
ARC-Keene	Arnie Johnson	8/25/03
Community Council-Nashua	Carol Farmer	8/29/03
ARC-Nashua	Bob Scheifele	8/29/03

APPENDIX B: NARRATIVE SUMMARY OF INTERVIEW PROCESS

The following are narrative comments by the Consultant Interviewers. They were instructed to include a brief summary of the overall experience of conducting these interviews. They were also asked to describe the level of cooperation from the agencies, problems encountered, questions that were raised by interviewees, suggestions to improve the process and any recommendations for system enhancements that may not have been captured with this instrument.

- None of the people I contacted had received the introductory letter.
- Many stated that the survey could have been done over the phone.
- A few agencies were reluctant to talk to me at first as I was from the "state".
- One problem I found was trying to get the right phone # and then the right person to interview especially at hospitals.
- Scheduling several people at one place was of some difficulty as their schedules differed. Most agencies wanted more than one person in on the interview.
- Overall everyone felt that the fire dept should be the first line of command, police second and behavioral health would not be an issue for weeks after.
- General response to project was very good. Most people were willing to meet and provide their input.
- Those in North Country particularly feel that their needs are not being heard and they need more resources.
- Unable to get response from Memorial Hospital and Huggins Hospital
- People want to know what will become of information provided and what kind of response can be expected.
- May have overlooked private practitioners and school staff in Lakes Region to participate in needs assessment survey
- A number of people couldn't answer #25 because they weren't sure if the people needed to have certain credentials.
- Difficulty in getting some of the key players to participate in the needs assessment process.
- Difficulty in getting substance abuse provider participation in N.A. process
- Hint of "turf" concerns-how DBH might be stepping on their toes.
- Some first responders in some communities may be reluctant to engage in debriefing
- Dismayed by overall lack of preparedness. If there is a major disaster we are in trouble.
- Several interviewees were not aware of the resources around them and did not have a sense of disaster terminology to even discuss the issues.
- Most agencies in the event of a disaster would put priorities on their own needs. Releasing staff is probably not a reality especially for any period of

time. A number of individuals have several conflicting roles/responsibilities and would need to respond to their primary jobs.

- Disagreement over CISD/CISM needs to be sorted out. CISD is only one piece of the CISM framework. The literature seems to suggest that to do it poorly is worse than not at all.
- Communication is still a challenge. In a recent drill in Merrimack, police and fire could not physically communicate directly with the school personnel.
- We may have sufficient resources to manage small-scale disasters but not large scale.
- We don not have sufficient MH staff in some areas. We need to look at paraprofessionals and people who are use to dealing with people to give psychological first aid. We need to consider the use of teachers (if schools were closed) and retirees as a resource.

APPENDIX C:
ADVERTISEMENTS FOR CONSULTANTS

The NH Division of Behavioral Health is seeking to contract with a consultant to work with the NH Disaster Behavioral Health Advisory Committee. This position requires a flexible schedule of 10-20 hours per week at $40/hour. Statewide travel is to be reimbursed at .36 per mile. Utilizing a recently developed disaster mental health needs assessment tool, the consultant will assess: 1) the current on-call systems of behavioral health providers; 2) the behavioral health resources that each region has used in the past to respond to disasters; 3) the current capacity of behavioral health providers to respond to all levels of disasters; 4) training needs; 5) the partnerships/relationships among various entities involved in emergency preparedness and response; and 6) the factors that may influence future demand for disaster mental health services. The consultant will work closely with the community mental health centers as well as other public/providers of behavioral health services. The consultant will be expected to provide weekly update reports, a final written analysis and presentations to key stakeholders of the assessment findings. Applicants must have an understanding of the behavioral health system, good communication skills, basic computer skills and the ability to produce timely reports. Previous experience in interviewing professionals either in focus groups or through structured interviews is desired.

Proposals should be received before 4:00 pm on Thursday, June 5, 2003 at the address below:

Paul Deignan, MH/SA Disaster Coordinator
The Division of Behavioral Health
State Office Park South
105 Pleasant Street, Main Bldg., Rm. 207S
Concord NH 03301

Copies of this RFP can be downloaded from our web site at: www.dhhs.state.nh.us/DHHS/DBH/LIBRARY/RFP/default.htm or by contacting Paul Deignan at 603-271- 0846. This is not a state position.

APPENDIX D: DISATER BEHAVIORAL HEALTH NEEDS ASSESSMENT SURVEY TOOL

John A. Stephen
Commissioner

Geoffrey C. Souther
Acting Director

STATE OF NEW HAMPSHIRE

DEPARTMENT OF HEALTH AND HUMAN SERVICES

DIVISION OF BEHAVIORAL HEALTH

105 PLEASANT STREET, CONCORD, NH 03301
603-271-5000 TDD Access: 1-800-735-2964

Disaster Behavioral Health Needs Assessment and Preparedness Survey

Community-Related Questions

1. What methods of coping has your community used in the past to respond to disasters such as fires, school suicides, etc. Please check all that apply.

   ☐ Don't Know
   ☐ Critical Incidence Stress Management (CISM)
   ☐ support groups
   ☐ crisis counseling
   ☐ outreach
   ☐ psychotherapy
   ☐ mental health screenings
   ☐ public education forums
   ☐ _____
   ☐ _____

2. What formal and/or informal resources in your community currently exist to respond to disasters?

   ☐ Don't Know
   ☐ American Red Cross
   ☐ emergency management
   ☐ crisis response team
   ☐ Salvation Army
   ☐ Citizens Corps
   ☐ church
   ☐ CISM Team
   ☐ Health Department/Officers
   ☐ _____
   ☐ _____

3. Are you aware of or do you participate in any local, regional, or statewide disaster planning efforts (committees, task forces, etc.)?

   ☐ Yes If yes, what? _____
   ☐ No

4. Are you aware of the individual who takes a leadership role or who is responsible for emergency management and/or planning response in your community?

   ☐ Yes If yes, who is it? _____
   ☐ No ☐ Don't Know

5. Are you aware of any interagency agreement(s) in your community that specify roles, responsibilities, and expectations of each other in the event of a disaster?

   ☐ Yes If yes, please describe: _____
   ☐ No ☐ Don't Know

6. Based on your assessment of community needs, do you have a disaster plan to provide culturally competent and linguistically appropriate services?

   ☐ Yes If yes, please describe: _____
   ☐ No ☐ Don't Know

7. In your opinion, how can disaster behavioral health response be improved in your community?

_____

_____

_____

Agency-Related Questions

8. Have you provided services to people who were affected by terrorist activities since September 11th?

   ☐ Yes If yes, please describe: _____
   ☐ No ☐ Don't Know

9. What types of disaster-related services is your agency currently online to provide? Please check all that apply.

   ☐ None
   ☐ Don't Know
   ☐ crisis counseling
   ☐ community group meetings/forums
   ☐ family groups/meetings
   ☐ psychotherapy
   ☐ school-based groups/meeting
   ☐ 24-hour emergency services
   ☐ CISM
   ☐ _____

10. What types of <u>additional</u> disaster-related services is your organization planning to make available in the next year? Please check all that apply.

    ☐ None
    ☐ Don't Know
    ☐ crisis counseling
    ☐ community group meetings/forums
    ☐ family groups/meetings
    ☐ psychotherapy
    ☐ school-based groups/meeting
    ☐ 24-hour emergency services
    ☐ CISM
    ☐ _____

11. Do you have any disaster-related material that can be disseminated to the general public (i.e., media releases, community flyers, information for high-risk groups, etc.)?
    ☐ Yes ☐ No ☐ Don't Know

12. Would you be interested in obtaining disaster-related material that can be disseminated to the general public?
    ☐ Yes ☐ No ☐ Don't Know

13. Do you have an external disaster response plan?
    ☐ Yes ☐ No ☐ Don't Know

14. Is your agency part of a hospital plan that has a mental health component to their emergency disaster plan?
    ☐ Yes ☐ No ☐ Don't Know

15. Do you have a plan to mobilize and release staff from your agency with short notice to respond to disasters?
    ☐ Yes If so, how many? _____
    ☐ No ☐ Don't Know

16. Have any staff members (those who could be mobilized and released to respond to disasters) had some training in disaster mental health issues such as CISM, Red Cross, trauma, etc.?
    ☐ Yes If yes, about how many? _____
    ☐ No ☐ Don't Know

17. Do you have an up-to-date list of skilled staff (those who could be mobilized) with training, credentials, experience, and contact information?
    ☐ Yes ☐ No ☐ Don't Know

18. Of those trained staff that could be mobilized and released, how many have had direct experience (this may include participation in simulated drills) in responding to disasters?
    ☐ _____ ☐ None ☐ Don't Know

19. What types of disasters have your trained and available staff had experience in responding to?
    ☐ Don't Know
    ☐ None
    ☐ Suicides
    ☐ Natural disasters
    ☐ Large-scale disasters (federally declared)
    ☐ Terrorist activity
    ☐ Homicides
    ☐ _____

20. Do you have a method/tool for assessing behavioral health needs of victims immediately following a disaster?

☐ Yes If yes, what is it? _____
☐ No ☐ Don't Know

21. Do you have a plan to manage the emotional and/or behavioral needs of first responders?

☐ Yes ☐ No ☐ Don't Know

22. Have you participated in any disaster training or mock drills in your community?

☐ Yes If yes, what type, when and where? _____
☐ No

23. What disaster-related specific training topics do you feel your staff (or others in your community) needs?

☐ Don't Know
☐ Identifying disaster-related behavior
☐ Special populations concerns in a disaster
☐ Disaster response protocols
☐ The disaster recovery process
☐ Key concepts of disaster mental health
☐ Effective interventions with disaster survivors
☐ Effective interventions at the community level
☐ Crisis Counseling (FEMA approach)
☐ Critical incident stress management (CISM)
☐ Red Cross disaster mental health training
☐ Prevention and management of stress among disaster mental health workers before, during and after incident
☐ Roles, responsibilities and resources of disaster response agencies
☐ Effective interventions of first responders
☐ Post-traumatic stress syndrome
☐ _____
☐ _____

24. Would your agency be willing to accept referrals after a disaster by being part of a statewide directory of providers for disaster behavioral health?

☐ Yes ☐ No ☐ Don't Know

25. Can you recommend anyone within your community who may be interested or appropriate to serve on our disaster behavioral health response team?

_____

_____

_____

26. What do you see as barriers/limitations to your being able to fully implement a disaster response plan in your agency?

_____

_____

_____

Agency Surveyed: _____

Catchment Area: _____

Respondent Names:

_____ *Title:* _____

_____ *Title:* _____

_____ *Title:* _____

_____ *Title:* _____

Survey Conducted By: _____ *Date:*_____

APPENDIX E: SUMMARY DATA FORM

Nicholas J. Vailas
Commissioner

Geoffrey C. Souther
Acting Director

STATE OF NEW HAMPSHIRE

DEPARTMENT OF HEALTH AND HUMAN SERVICES

DIVISION OF BEHAVIORAL HEALTH

105 PLEASANT STREET, CONCORD, NH 03301
603-271-5000 TDD Access: 1-800-735-2964

Disaster Behavioral Health Needs Assessment and Preparedness Survey SUMMARY DATA FORM

Community-Related Questions

1. What methods of coping has your community used in the past to respond to disasters such as fires, school suicides, etc. Please check all that apply.

☐ Don't Know (overall __2 cmhc____, ARC __1__,Hospitals__1__)
☐ Critical Incidence Stress Management (CISM) (overall_36___, cmhc __11__, ARC __4 Hospitals __11
☐ support groups(overall __35__,cmhc_11_, ARC__5__, Hospitals__12__)
☐ crisis counseling(overall__38__,cmhc_12__ ARC__4__, hospitals__10__)
☐ outreach(overall_25__, cmhc10 ARC__4_, hospitals_6__)
☐ psychotherapy(overall_20__, cmhc__10_ ARC_2 hospitals__6_)
☐ mental health screenings(overall_20__,cmhc_9__ ARC__1_, hospitals_6__)
☐ public education forums(overall_22__, cmhc_11_, ARC_3__, hospitals_4__)

reality checks, fire and police grief groups, hospice, EAP, debriefing with ARC, informal crisis response teams, Victims Inc. Chaplains/Ministers, informal network of professionals called together when needed.

2. What formal and/or informal resources in your community currently exist to respond to disasters?

☐ Don't Know(overall___, cmhc___ ARC___, Hospitals___)
☐ American Red Cross(overall_48__, cmhc_10_ARC_6__hospitals_11
☐ emergency management(overall_27__ cmhc_7__, ARC_4__, hospitals_8__)
☐ crisis response team(overall_18 cmhc_5_ ARC_2__, Hospitals_5__)
☐ Salvation Army(overall_26__, cmhc__7 ARC_4 hospitals__6
☐ Citizens Corps(overall_2__, cmhc___ ARC_1__, hospitals___)
☐ church(overall_28 cmhc_6_

ARC__4 hospitals_10__)
☐ CISM Team(overall_24__cmhc_6__ ARC_3 hospitals_8
☐ Health Department/Officers(overall_24__ Chic 5__, ARC_3__, hospitals_9__)

hospital CISM, Plymouth State College, town welfare dept., private practitioners, Epic's, emergency Psychiatry. Fire Chaplain, EAP, NHVOAD, Good news ministries, school has own team, Citizens Corps, Hospitals, CMHC, Fire Dept.

mutual aid, fire & police. Informal networks. Granite State CISM, Clergy,

3. Are you aware of or do you participate in any local, regional, or statewide disaster planning efforts (committees, task forces, etc.)?

   ☐ Yes (overall_45__cmhc_10__ARC_7__ hospitals_15__)
   If yes, what?
   DBHAC, ARC, FEMA, Mayor's Anti-Terrorism Task Force, State CISD team, local police, fire and hospital, DBH-ES Directors meetings, Community Health and Safety Initiative, Lancaster Crisis Response Team, statewide hospital disaster planning group, local smallpox community plan, NHHA Task Force, Region I District EMS Councils, statewide B.T. Emergency Prep. EMS/Public Health Interaction Collaborative, LEPC-Laconia, Hazard Mitigation, local crisis response team, local EMS, Lebanon Emergency Plan, Lebanon-Lebanon and Hanover, Mascara Valley Health Initiative, Vermont state committees, NHHA, ED Nurses, Rochester School District Crisis Plan, Northern Strafford County Health Alliance, community table top drills, Portsmouth Biohazard drill, SW/NH Reg. Planning Comm., LEPC-Nashua, Merrimack EMA.
   ☐ No (overall9cmhc_4__ARC_1__hospitals_1__)

4. Are you aware of the individual who takes a leadership role or who is responsible for emergency management and/or planning response in your community?

   ☐ Yes (overall_44cmhc_9__ARC_8__hospitals_13_
   ☐ No (overall_8__cmhc__4_ARC___hospitals___)
   ☐ Don't Know (overall_3_cmhc_1 ARC___hospitals_2__)

5. Are you aware of any interagency agreement(s) in your community that specify roles, responsibilities, and expectations of each other in the event of a disaster?

   ☐ Yes (overall_34__cmhc6__ARC_2__hospitals_2__)
   If yes, please describe:
   fire, police, health dept., social services, ARC, state, task forces, FEMA hospitals, Mutual Aid agreements between Fire Depts., Town Disaster Plan, Littleton Hospital with Public Safety Officers, EMS/Fire Mutual Aid, Police Mutual Aid, Lakes Region Mutual Fire Aid Assoc., CMHC/Claremont school district, CMHC/Valley Regional Hospital, CMHC/Newport School District, ARC/Shelter Agreements at local level, ARC/National MOU, ARC/Mutual Aid compact, shelter agreements, vender agreements, collaborative hospital agreements, EMS collaborations and mutual aid agreements, MFS/Cheshire Med. CTR., Keene EMA Plan, Community Council of Nashua/Nashua Public Health dept MOU, ARC and many org. national MOU's, NHHA Mutual Aid Agreement, Nat. Dis. Medical System.

☐ No(overall__17_cmhc_7__ARC_1__hospitals_5__)
☐ Don't Know(overall_4__cmhc_1__ARC___hospitals___)

6. Based on your assessment of community needs, do you have a disaster plan to provide culturally competent and linguistically appropriate services?

☐ Yes(overall_26__cmhc_7ARC_6__hospitals_8
If yes, please describe:
AT&T language line, Bi-lingual staff, VA database, interpreters in-house and on list of resources, ARC has "Diversity training" local language bank, list of interpreters in hospital, Lutheran Child & Family services statewide plan, not much diversity, college language professors and foreign students-KSC, churches, ethnic restaurants, ARC has literature in 14 languages, Public Health interpreters.
☐ No(overall_21__cmhc_6__ARC___hospitals_6__)
☐ Don't Know(overall_5__cmhc_1__ARC_1__hospitals__1_)

7. In your opinion, how can disaster behavioral health response be improved in your community?

OVERALL

1. Set up agreements with local CMHC
2. Awareness of visually impaired and special needs
3. Public awareness-state put together resource manual for all
4. More local involvement in planning.
5. Improve communication and awareness in the community
6. Formal agreements & linkage written into city plan
7. More knowledge of languages and money for interpreters
8. Public awareness and education on B.H. and disaster planning-(what is expected and what is normal response, where to go for help and assistance).
9. Relationship building between responding entities
10. Need integrated team-identify resources and be willing to formalize relationships
11. Need dialogue among service providers.
12. Look at role of M.H. to assist local populations e.g. CISD for emergency personnel
13. Get all players together to devise plan and adding responsibilities
14. Develop a local volunteer network of translators
15. Have individuals who are occupying beds in the ED due to MH issues get assessed and moved along
16. System to oversee resources
17. Better plan for follow-up, post disaster
18. Break down barriers between agencies e.g. ARC
19. By establishing a community task force
20. Need more training
21. More public education/awareness

CMHC

1. More communication with other agencies
2. Communication, networking with other agencies. Have a relationship with police and corrections

3. Better communication between local and state practice. Unclear who is the leader in the state. Too much relying on ES to handle and coordinate when they are needed on the front line
4. More coordination between organizations
5. Training-need to provide incentives since training is not billable time. Need North Country training
6. Recruitment of more trained providers of M.H. services into community and more disaster response training
7. Increased funding to compensate for time to meet coordination efforts and time spent in training
8. Coordinated response with other organizations
9. Added resources in the event of an overwhelming disaster
10. Having a structured and trained disaster response team with identified leader
11. Drills in community
12. Support for process of planning
13. Better awareness of CMHC as community resource
14. Need community groups to organize and then have their role clearly articulated in the local disaster plan.
15. Try not to reinvent the wheel. There is an overlap of responsibilities at county and local levels
16. Lack of details and substance.
17. Increased training opportunities, with money to help with coverage when staff is being trained

ARC

1. More networking. How do we reach the right person to make the right calls? What is the next step?
2. Interagency training and awareness so each understands their capabilities and limitations
3. Little need. Mostly single family house fires
4. Need to keep volunteers interested and involved with training, drills, etc.
5. Red Cross needs to be notified to provide services
6. First responders not mental health proficient
7. Locate volunteer network of translators
8. Increase overall cultural competence training

HOSPITALS

1. Improved resources in regard to linguistic issues
2. Increase number of resources-personnel
3. Education
4. Increase communication ability among agencies
5. More skilled resource people
6. Is there a network for other communities t respond in Franklin? No private people in the area. Need back up.
7. Lack of M.H. services in North Country
8. For small town communities need planning for small-scale disasters

9. Every organization needs to revisit disaster plans and update them to include M.H. component
10. Lack of funding for hospital B.H. response team (Chaplain)
11. Need a system of community M.H. that functions for day-to-day problems of individuals in crisis. This is currently lacking.
12. Need formal links with CMHC. What types of services are needed and when. Build into drills.
13. Special training needed both ways. M.H. people need disaster training and disaster responders need mental health training.
14. Better coordination of roles . Eliminate redundancy.
15. Develop and distribute a list of community resources available for disaster response

Agency-Related Questions

8. Have you provided services to people who were affected by terrorist activities since September 11th?

☐ Yes(overall_35__cmhc_10__ARC_7hospitals_9__

If yes, please describe:

- Responded to individual needs and concerns.
- Provided family support groups, individual assessments for family survivors and public education. Sent volunteers and materials to N.Y.C.
- Evaluated individuals.
- Short term(30 days) counseling to existing clients
- Medical services to persons directly involved in NYC
- Hospital Chaplain provide services to friends of those directly involved
- Education and training on specific topics such as smallpox
- Have website for resources and referrals
- Crisis intervention
- Psychotherapy
- Outreach to schools, colleges and universities
- A few encounters in local E.R.
- New brochures and community presentations/forums
- Public access T.V.
- Hotline-crisis and addiction counseling
- Seminars for local companies
- Work with families of military
- Provided depression and anxiety screenings
- DRN members through local ARC have accepted referrals and provided pro bono services

☐ No(overall_19__cmhc_4__ARC_1__hospitals_6

☐ Don't Know(overall_1__cmhc___ARC___hospitals_1__)

9. What types of disaster-related services is your agency currently online to provide? Please check all that apply.

☐ None(overall_5__cmhc___ ARC___hospitals_2__)

☐ Don't Know(overall_1__cmhc___ ARC___hospitals___)

☐ crisis counseling(overall_36__cmhc_14__ ARC_5__hospitals_9__)
☐ community group meetings/forums(overall_28__cmhc_10__ ARC_3__hospitals_7__)
☐ family groups/meetings(overall__41_cmhc_11_ _ARC_3__hospitals_8__)
☐ psychotherapy(overall_25__cmhc_13_ _ARC_2__hospitals__7_)
☐ School-based groups/meeting(overall_28__cmhc_13__ ARC_4__hospitals_6__)
☐ 24-hour emergency services(overall_38__cmhc_13__ ARC_4hospitals_11
☐ CISM(overall__22_cmhc_10__ ARC_2__hospitals_7__)

☐ Media response, CPI, mutual aid, grief groups, ARC is developing disaster M.H. , line of services, educational programming. CISD, disaster/blood/health/safety courses, addiction counseling, pastoral counseling, forensic evaluations, MH info on computer, consults to medical floors, EAP services.

10. What types of <u>additional</u> disaster-related services is your organization planning to make available in the next year? Please check all that apply.

☐ None(overall_29__cmhc_7__ ARC_3 hospitals_8
☐ Don't Know(overall_3__cmhc_2__ ARC___hospitals_1__)
☐ crisis counseling(overall4__cmhc___ ARC___hospitals_2__)
☐ community group meetings/forums(overall_1__cmhc_1_ ARC___hospitals___)
☐ family groups/meetings(overall___ cmhc___ARC___hospitals___)
☐ psychotherapy(overall___cmhc___ ARC___hospitals___)
☐ school-based groups/meeting(overall_4__cmhc_2__ ARC_2__hospitals___)
☐ 24-hour emergency services(overall_2__ cmhc___ARC_2__hospitals___)
☐ CISM(overall__2_cmhc___ ARC_2__hospitals___)

expand mass care, update response plans/policies, train staff in CISD, staff training, development of MOU's, emergency planning, distance learning, ARC disaster canteen, more community education, "Facing Fear" programs for schools, more training by ARC,

11. Do you have any disaster-related material that can be disseminated to the general public (i.e., media releases, community flyers, information for high-risk groups, etc.)?

☐ Yes(overall_28__cmhc_8 ARC8 hospitals_5
☐ No(overall__20_cmhc_5__ARC___hospitals_10__)
☐ Don't Know(overall_4__cmhc_1__ARC___hospitals__1_)

12. Would you be interested in obtaining disaster-related material that can be disseminated to the general public?

☐ Yes(overall_53__cmhc 13___ARC_7__hospitals_15__
☐ No(overall_1__cmhc___ARC__1_hospitals___)
☐ Don't Know(overall_1__cmhc__1_ARC___hospitals___)

13. Do you have an external disaster response plan?

☐ Yes(overall_42 cmhc_10 ARC 8__hospitals 15
☐ No(overall_12__cmhc_3__ARC___hospitals_0__)
☐ Don't Know(overall_1__cmhc_1__ARC___hospitals___)

14. Is your agency part of a hospital plan that has a mental health component to their emergency disaster plan?

☐ Yes(overall_28__cmhc_9__ARC_4 hospitals_NA__
☐ No(overall_16__cmhc_2__ARC___hospitals_NA__)
☐ Don't Know(overall_11__cmhc_3__ARC__5 _hospitals__NA_

15. Do you have a <u>plan</u> to mobilize and release staff from your agency with short notice to respond to disasters?

☐ Yes(overall_43__cmhc_12__ARC_8 hospitals__9_)
If so, how many?(overall_320 cmhc_61__ARC_109__hospitals_108__)
☐ No(overall_10__cmhc_2 ARC___hospitals_5__)
☐ Don't Know(overall_1__cmhc___ARC___hospitals__1_)

16. Have any staff members (those who could be mobilized and released to respond to disasters) had some <u>training</u> in disaster mental health issues such as CISM, Red Cross, trauma, etc.?

☐ Yes(overall_33__cmhc_13__ARC__7_hospitals_8__)
If yes, about how many? (overall_343__cmhc_144 ARC_27__hospitals_22__)
☐ No(overall_13__cmhc_1__ARC_1__hospitals_5__)
☐ Don't Know(overall_2_cmhc___ARC___hospitals__2_)

17. Do you have an up-to-date <u>list</u> of skilled staff (those who could be mobilized) with training, credentials, experience, and contact information?

☐ Yes(overall_41__cmhc__11_ARC_7 hospitals_9
☐ No(overall_13__cmhc_4__ARC_1__hospitals_5__)
☐ Don't Know(overall_1__cmhc___ARC___hospitals__1_)

18. Of those trained staff that could be mobilized and released, how many have had direct <u>experience(this may include participation in simulated drills)</u> in responding to disasters?

☐ (overall_464__cmhc_133__ARC_158__hospitals_70
☐ None(overall_10 cmhc_3__ARC_1__hospitals_2__)
☐ Don't Know(overall__3_cmhc_1__ARC___hospitals___)

19. What types of disasters have your trained and available staff had experience in responding to?

☐ Don't Know(overall_1__cmhc___ ARC___hospitals___)
☐ None(overall__5_cmhc_1__ ARC___hospitals_1__)
☐ Suicides(overall_38__cmhc_14__ ARC_3__hospitals__10_)
☐ Natural disasters(overall_29__cmhc__3_ ARC_8__hospitals_10__)
☐ Large-scale disasters (federally declared)(overall_20__cmhc_3__ ARC__6_hospitals_3__)
☐ Terrorist activity(overall_19__cmhc__2_

ARC_5__hospitals_6_)
☐ Homicides(overall_30__cmhc_1__ ARC_22__hospitals__7_
☐ fires (home and forest), auto accidents, floods, power outages, kidnapping, bomb threats, airline crash, bank robberies, mass casualty incidents, grief work in schools, deaths, deaths on campus, chemical spills.

20. Do you have a method/tool for assessing behavioral health needs of victims immediately following a disaster?

☐ Yes(overall_18_cmhc_6__ARC__5_hospitals_6__)
If yes, what is it? PCLS, EAP, Lethality assessment, depression screening, individual assessments, CISM-Mitchell model, ES Contact sheet, Suicide risk assessment.
☐ No(overall_30__cmhc_8__ARC_3 hospitals__9_)
☐ Don't Know(overall_2__cmhs___ARC___hospitals__1_)

21. Do you have a plan to manage the emotional and/or behavioral needs of first responders?

☐ Yes(overall__35 cmhc_9__ARC_6__hospitals_11__)
☐ No(overall_19 cmhc_4__ARC_2__hospitals_4__)
☐ Don't Know(overall_1__cmhc__1_ARC___hospitals___)

22. Have you participated in any disaster training or mock drills in your community?

☐ Yes(overall__27_cmhc_3__ARC_7__hospitals_14__)
If yes, what type, when and where? Decontamination, hostage, chemical, nuclear, aviation, kidnapping, smallpox, school shooting, bomb threats, anthrax, bioterrorism radiation, pediatric burns, earthquake-building collapse, local hospital based drills, Lancaster, hazardous materials, auto crash into a large crowd, haz-mat drill, terrorism, floods, mass disasters (table top), bus accident, set up field hospital with National Guard, Pease airport disaster drill, Hampton WMD excercize-2003, TOPOFF-2000, Seabrook Station disaster drill, Manchester airport drill, Hollis Fire drill, Vermont drills, Vermont Yankee, Community Council of Nashua with SNHMC, ARC with chemical spills and airport disasters, SNHMC-disaster recall list, CISM simulations, ARC drills.
☐ No (overall__20_cmhc_11__ARC_1__hospitals_1__)

23. What disaster-related specific training topics do you feel your staff (or others in your community) needs?

☐ Don't Know (overall_5__cmhc___hospitals_1_)
☐ Identifying disaster-related behavior (overall_29__cmhc_10__hospitals_7__)
☐ Special populations concerns in a disaster (overall_30__cmhc__10 _hospitals__5_)
☐ Disaster response protocols (overall_31__cmhc_11__hospitals__7_)
☐ The disaster recovery process (overall_25 cmhc_11__hospitals7___)
☐ Key concepts of disaster mental health (overall_32__cmhc_10__hospitals_9__)
☐ Effective interventions with disaster survivors (overall_33__cmhc10___hospitals_9
☐ Effective interventions at the community level (overall__32_cmhc_10_ hospital' s__7_)
☐ Crisis Counseling (overall_34__cmhc_10__hospitals_6__)
☐ Critical incident stress management (overall_32__cmhc11___hospitals_7__)
☐ Red Cross disaster mental health training (overall__26_cmhc__9_hospitals 4___)

☐ Prevention and management of stress among disaster mental health workers before, during and after incident (overall__33_cmhc_11__hospitals10___)
☐ Roles, responsibilities and resources of disaster response agencies (overall__38_cmhc_12__hospitals_12__)
☐ Effective interventions of first responders (overall_31__cmhc_9__hospitals__9_)
☐ Post-traumatic stress syndrome(overall_28 cmhc__6_hospitals_7__)

needs of handicapped, understanding command center role
How to deal with large-scale disasters, community roles in disasters, regional planning-roles and responsibilities, communication protocols/systems, understanding terrorism, Intro to Disaster for community, Hands-on training, Incident Command, hazard recognition, decontamination, building safety

24. Would your agency be willing to accept referrals after a disaster by being part of a statewide directory of providers for disaster behavioral health?
☐ Yes (overall__42_cmhc_13__hospitals__10_)
☐ No (overall_4__cmhc___hospitals__2_)
☐ Don't Know (overall__5_cmhc___hospitals_2_)

25. Can you recommend anyone within your community who may be interested or appropriate to serve on our disaster behavioral health response team

26. What do you see as barriers/limitations to your being able to fully implement a disaster response plan in your agency?

Overall

1. Money to pay staff
2. Limited staff available, facility limitations
3. Volunteers need more training
4. Need awareness of disabled and special needs
5. Time and money
6. Lack of staff
7. Confidentiality of clients
8. To release people for training would compromise regular services to clients and impact revenue
9. Point person needed to handle M.H. issues
10. Lack of training and funding for training
11. Getting licensed MH workers trained to work as volunteers.
12. Understanding the roles of the behavioral health teams by existing systems.
13. Cross training
14. Lack of awareness and concern

CMHC

1. Staff resources
2. Financial
3. Time

4. Having an appropriate plan
5. Will staff be paid? Performance standards will be affected
6. Will there be CEU's?
7. Stigma associated with "mental health" prevents people from seeking help
8. Turf issues-role of M.H. for first responders. Need to build bridge between police, schools and
9. Limited # of M.H. providers
10. When disaster strikes staff and community are in state of shock and can be immobilized
11. Difficult to free time for training and distance from training locations
12. Lack of funding to cover staff while being trained
13. Staff too busy with day to day issues and current clients
14. Pressure to meet productivity/revenue goals
15. Getting the community on board
16. Lack of coordination-who's doing what?
17. Lack of training; not organized for it. Need for state to make it a priority(responsive and efficient)
18. Need to work the process-better communication and organization at County and regional level. Need key person identified in each community
19. Inability to deploy large numbers of staff on short notice, particularly during work time as funding is dependent upon seeing clients who need to be seen.
20. Sees hospital as leader

ARC

1. Apathy-not enough disasters so people lose interest
2. Mostly an all-volunteer agency
3. Building disaster action teams to include M.H./ special populations
4. Scale- covers so many communities-lot of Incident Commanders
5. Lack of awareness of ARC or won't call because of stigma (blood only)
6. Funding
7. LEPC's are critical
8. Keeping interest of volunteers
9. More endorsement of M.H. component-image and perception

HOSPITALS

1. Lack of behavioral health specialists
2. Too much information arriving from the state. It changes and not everyone has the same information.
3. Financial
4. Appropriate training
5. Need for large scale drills using behavioral health interventions
6. Direction and guidance
7. Time, people and resources
8. Funding for staff positions
9. Availability of M.H. workers
10. Funding for equipment

11. Lack of coordination and communication among agencies
12. Lack of hospital Incident Command System
13. Need training and leadership not federal dollars
14. No one is coming into Plymouth area to help
15. No one person to coordinate and be accountable
16. Need to build Disaster behavioral health into hospital incident command system protocol
17. Looking for state to provide guidelines/checklists with timelines for when services are needed and target groups
18. Can't be agency specific. Need cross agency training
19. Education
20. Different organizations are using different comm. equipment
21. Capacity and duration

APPENDIX F: GLOSSARY OF TERMS

ARC- American Red Cross

CDC- Center for Disease Control

CISD- Critical Incident Stress Debriefing

CISM- Critical Incident Stress Management

Citizen Corps- a unified, national approach to citizen preparedness by linking a variety of new and existing volunteer activities focusing on crime prevention and disaster response.

CMHC- Community Mental Health Centers

DBH- Division of Behavioral Health

DHHS- Department of Health and Human Services

EAP- Employee Assistance Program

ED- Emergency Department

EMS- Emergency Medical Services

FEMA- Federal Emergency Management Agency

ICS- Incident Command System

LEPC- Local Emergency Planning Committee

MHCGM- Mental Health Center of Greater Manchester

MOU- Memorandum of Understanding

NHHA- New Hampshire Hospital Association

NHVOAD- New Hampshire Voluntary Organizations Active in Disaster

OCPH- Office of Community and Public Health

PSA- Public Service Announcement

PTSD- Past-traumatic stress disorder

SAMHSA- Substance Abuse and Mental Health Services Administration

SNHRMC- Southern New Hampshire Regional Medical Center

VA- Veteran's Administration

WMD- Weapons of Mass Destruction